

The Lincoln National Life Insurance Company ("Lincoln")
Lincoln Life & Annuity Company of New York ("Lincoln")
First Penn-Pacific Life Insurance Company ("Lincoln")

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This form should be completed by the Licensed Health Care Practitioner (MD, DO, RN, or Licensed Social Worker) recommending care services for the Insured.

Step 1 - Guidance

Enter the policy or certificate number.

Enter any other relevant policy or certificate numbers separated by commas.

Step 1 - Insured Information

Policy Number:

First Name:

Last Name:

Date of Birth: / /

Step 2 - Guidance

Answer all the questions in this section.

Primary Diagnosis is the reason for Long-term Care services outlined in this Plan of Care.

Indicate any additional diagnoses, date of diagnosis, and ICD code for each.

Print versions of physician notes are acceptable; please attach.

Step 2 - Medical Information

Date you first treated/consulted this patient: / /

Date you last assessed this patient: / /

Primary diagnosis related to reason for care: (including ICD code)

Primary Diagnosis:

ICD code:

Date of primary diagnosis or date symptoms appeared (mm/dd/yyyy): / /

Additional diagnoses related to plan of care: (including ICD codes)

Diagnosis:

Date (mm/dd/yyyy): / / ICD code:

Diagnosis:

Date (mm/dd/yyyy): / / ICD code:

Step 2 - Guidance

If additional space is needed or if there are additional diagnoses, attach page(s).

Indicate medications, if applicable. Medication list can be printed and attached.

If no medications are currently prescribed, indicate 'none taken' in the space provided.

Additional diagnoses related to plan of care: (including ICD codes)

Diagnosis:

Date (mm/dd/yyyy): / / **ICD code:**

Diagnosis:

Date (mm/dd/yyyy): / / **ICD code:**

Diagnosis:

Date (mm/dd/yyyy): / / **ICD code:**

Diagnosis:

Date (mm/dd/yyyy): / / **ICD code:**

Diagnosis:

Date (mm/dd/yyyy): / / **ICD code:**

Additional details about the Insured's medical condition:

Medications currently prescribed:

Step 3 - Guidance

Provide your recommendation of the assistance required for each of the Activities of Daily Living, as it applies to the Insured.

Bathing- Getting into and/or out of the tub or shower. Washing your body or hair in a tub, shower or by sponge bath.

Dressing- Putting on and/or taking off any necessary item of clothing (including undergarments) and any necessary braces, fasteners or artificial limbs.

Eating- Feeding yourself by getting food into your mouth from a container, including use of utensils or by feeding tube or intravenously.

Toileting- Getting to/from and/or on/off toilet and performing associated personal hygiene.

Transferring- Getting into and/or out of a bed, chair or wheelchair.

Continence- Maintaining control of bowel and bladder function or performing associated personal hygiene (catheter or colostomy bag).

Step 3 - Recommended Plan of Care

Recommended duration of services:

Less than 3 months

3-6 months

6-12 months

12 month+

Check the most appropriate response for each activity.

ADLs	0 Independent (with or without assistive device)	1 Supervision or Set-Up Only	2 Standby assistance of another person	3 Hands-on assistance of another person	4 Completely dependent
Bathing					
Dressing					
Eating/Feeding					
Toileting					
Transferring					
Continence					

Additional Details:

Step 4 - Guidance

Levels of dependence for Instrumental Activities of Daily Living (IADLs) are defined as:

- 1- Never needs assistance from anyone (Independent)
- 2- Requires assistance from another person for some of the Instrumental Activities of Daily Living (Partially Dependent)
- 3- Needs total assistance from another person to complete Instrumental Activities of Daily Living (Totally Dependent)

The person assisting with Instrumental Activities of Daily Living should be indicated as follows: family member, facility staff, friend, Home Health Aide (HHA), etc.

Step 4 - Recommended Plan of Care continued

Indicate the level of IADL dependence in the chart below:

IADLs	1 Independent	2 Partially Dependent	3 Totally Dependent	Indicate who assists with IADL
Meal Preparation				
Medication Management				
Shopping				
Laundry				
Transportation Arrangements				
Driving				
Telephone Use				
Money Management				

Step 5 - Guidance

Complete the medical equipment chart, identifying the equipment that the patient currently uses and the equipment that is needed.

If additional space is needed, attach page.

If this section is left blank, it is assumed that no medical equipment is needed.

Step 5 - Recommended Plan of Care continued

Identify medical equipment that the patient has or needs in the chart below:

Equipment	In Use	Needed	Equipment	In Use	Needed
Bedside Commode			Lift Chair		
Cane			Walker		
Gait Belt			Wheelchair		
Grabber/Reacher			Medical Alert		
Grab Bars in Bathroom			Ramp for Home		
Handheld Showerhead			Stair Lift		
Raised Toilet Seat			Tub Bench		
Electric/Hospital Bed			Other:		
Hoyer Lift			Other:		

Step 6 - Guidance

Important: If cognitive testing has been done, it is important to include a copy of the test results.

A copy of cognitive test results is required for cognitive impairment claims.

Failure to include a copy of the testing may delay the claim.

Step 6 - Recommended Plan of Care continued

Does the Insured have a cognitive deficit? Yes No

If yes, indicate the level of cognitive deficit present:

Mild Cognitive Impairment

Moderate Cognitive Impairment

Severe Cognitive Impairment

Type of Cognitive Diagnostic Test:

Test Date: / / Score:

Does the patient exhibit any behaviors that are of concern? Yes No

If yes, please specify:

Do you believe the patient is competent to endorse checks? Yes No

Do you believe the patient is competent to direct their financial affairs? Yes No

Step 7 - Guidance

As the Licensed Health Care Practitioner prescribing this plan of care, provide your information in this section.

Step 7 - Licensed Health Care Practitioner Information

First Name:

Last Name:

Title:

Mailing Address:

City:

State:

Zip Code:

Phone Number: - -

Fax Number: - -

Federal Tax ID Number:

License Number:

Step 8 - Guidance

Select the box that most accurately reflects your professional evaluation as a U.S. Licensed Health Care Practitioner.

The need for **substantial assistance** is hands-on assistance or the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the activity of daily living.

The need for **substantial supervision** is continual supervision (which may be cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired insured from threats to his or her health or safety (such as may result from wandering).

Read all pertinent fraud warnings on page 5 and 6. Sign this form to affirm that you have read the fraud warnings and that information provided on this Practitioner Plan of Care is complete and accurate. Signature is required by all states.

Step 8 - Certify and Sign This Plan of Care

Certification by U.S. Licensed Health Care Practitioner

Check all that apply:

I certify that the patient requires **substantial assistance** from another individual to perform at least **2 or more of the Activities of Daily Living** named in step 4, page 3 of this document. Condition is due to loss of functional capacity expected to last at least 90 days.

I certify that the patient requires substantial supervision to protect herself/himself or others from threats to health or safety due to a severe cognitive impairment.

I certify that the patient does not require substantial assistance or substantial supervision

By signing below, I acknowledge that I have read all FRAUD WARNINGS pertaining to my state.

(Signature is required for all states.)

Signature of Licensed Health Care Practitioner

Date: / /

Print Name of Licensed Health Care Practitioner

Specialty/Title

This form must be signed by a Licensed Health Care Practitioner, defined as:

A physician, as defined in Section 1861[®] (1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. The health care practitioner must be acting within the scope of his or her license when providing any Covered Service or performing necessary functions or actions under this rider.

Fraud Warning for New York Residents:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTE: There are Fraud Warnings **above** and in the **following Fraud Warning section.**

Fraud Warnings

Warning – Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files a statement of claim containing any false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material to the claim, commits a fraudulent insurance act, which may be a crime, and in certain states a felony. Penalties may include imprisonment, fines, denial of insurance and civil damages.

These states require the following fraud warnings:

California (For your protection, California law requires this to appear.) – Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – Any person who, with a purpose to injure, defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. Subsection 638:20.

New Jersey – Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (\$5,000) dollars and not more than ten thousand (\$10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.